General Assembly

Committee Bill No. 22

January Session, 2017

LCO No. **4610**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT LIMITING COST-SHARING FOR PRESCRIPTION DRUGS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-510 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2018*):

(a) No insurance company, hospital service corporation, medical service corporation, health care center or other entity delivering, issuing for delivery, renewing, amending or continuing an individual health insurance policy or contract that provides coverage for prescription drugs may:

(1) Require any person covered under such policy or contract to obtain prescription drugs from a mail order pharmacy as a condition of obtaining benefits for such drugs; **[**or**]**

(2) Impose a coinsurance, copayment, deductible or other out-of-pocket expense that exceeds one hundred dollars per thirty-day supply for a covered prescription drug, except that a high deductible health plan, as that term is used in subsection (f) of section 38a-493, shall not be subject to the deductible provision set forth in this subdivision until

after the minimum annual deductible for such plan has been met;

(3) Place all prescription drugs in a given class in the highest cost-sharing tier of a tiered prescription drug formulary; or

[(2)**]** (4) Require, if such insurance company, hospital service corporation, medical service corporation, health care center or other entity uses step therapy for such drugs, the use of step therapy for any prescribed drug for longer than sixty days. At the expiration of such time period, an insured's treating health care provider may deem such step therapy drug regimen clinically ineffective for the insured, at which time the insurance company, hospital service corporation, medical service corporation, health care center or other entity shall authorize dispensation of and coverage for the drug prescribed by the insured's treating health care provider, provided such drug is a covered drug under such policy or contract. If such provider does not deem such step therapy drug regimen clinically ineffective or has not requested an override pursuant to subdivision (1) of subsection (b) of this section, such drug regimen may be continued. For purposes of this section, "step therapy" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition are to be prescribed.

(b) (1) Notwithstanding the sixty-day period set forth in subdivision **[**(2)**]** (4) of subsection (a) of this section, each insurance company, hospital service corporation, medical service corporation, health care center or other entity that uses step therapy for such prescription drugs shall establish and disclose to its health care providers a process by which an insured's treating health care provider may request at any time an override of the use of any step therapy drug regimen. Any such override process shall be convenient to use by health care providers and an override request shall be expeditiously granted when an insured's treating health care provider demonstrates that the drug regimen required under step therapy (A) has been ineffective in the past for treatment of the insured's medical condition, (B) is expected to

be ineffective based on the known relevant physical or mental characteristics of the insured and the known characteristics of the drug regimen, (C) will cause or will likely cause an adverse reaction by or physical harm to the insured, or (D) is not in the best interest of the insured, based on medical necessity.

(2) Upon the granting of an override request, the insurance company, hospital service corporation, medical service corporation, health care center or other entity shall authorize dispensation of and coverage for the drug prescribed by the insured's treating health care provider, provided such drug is a covered drug under such policy or contract.

(c) Nothing in this section shall (1) preclude an insured or an insured's treating health care provider from requesting a review under sections 38a-591c to 38a-591g, inclusive, or (2) affect the provisions of section 38a-492i.

Sec. 2. Section 38a-544 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2018*):

(a) No insurance company, hospital service corporation, medical service corporation, health care center or other entity delivering, issuing for delivery, renewing, amending or continuing a group health insurance policy or contract that provides coverage for prescription drugs may:

(1) Require any person covered under such policy or contract to obtain prescription drugs from a mail order pharmacy as a condition of obtaining benefits for such drugs; **[**or**]**

(2) Impose a coinsurance, copayment, deductible or other out-of-pocket expense that exceeds one hundred dollars per thirty-day supply for a covered prescription drug, except that a high deductible health plan, as that term is used in subsection (f) of section 38a-520, shall not be subject to the deductible provision set forth in this subdivision until

after the minimum annual deductible for such plan has been met;

(3) Place all prescription drugs in a given class in the highest cost-sharing tier of a tiered prescription drug formulary; or

[(2)**]** (4) Require, if such insurance company, hospital service corporation, medical service corporation, health care center or other entity uses step therapy for such drugs, the use of step therapy for any prescribed drug for longer than sixty days. At the expiration of such time period, an insured's treating health care provider may deem such step therapy drug regimen clinically ineffective for the insured, at which time the insurance company, hospital service corporation, medical service corporation, health care center or other entity shall authorize dispensation of and coverage for the drug prescribed by the insured's treating health care provider, provided such drug is a covered drug under such policy or contract. If such provider does not deem such step therapy drug regimen clinically ineffective or has not requested an override pursuant to subdivision (1) of subsection (b) of this section, such drug regimen may be continued. For purposes of this section, "step therapy" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition are to be prescribed.

(b) (1) Notwithstanding the sixty-day period set forth in subdivision **[**(2)**]** (4) of subsection (a) of this section, each insurance company, hospital service corporation, medical service corporation, health care center or other entity that uses step therapy for such prescription drugs shall establish and disclose to its health care providers a process by which an insured's treating health care provider may request at any time an override of the use of any step therapy drug regimen. Any such override process shall be convenient to use by health care providers and an override request shall be expeditiously granted when an insured's treating health care provider demonstrates that the drug regimen required under step therapy (A) has been ineffective in the past for treatment of the insured's medical condition, (B) is expected to

be ineffective based on the known relevant physical or mental characteristics of the insured and the known characteristics of the drug regimen, (C) will cause or will likely cause an adverse reaction by or physical harm to the insured, or (D) is not in the best interest of the insured, based on medical necessity.

(2) Upon the granting of an override request, the insurance company, hospital service corporation, medical service corporation, health care center or other entity shall authorize dispensation of and coverage for the drug prescribed by the insured's treating health care provider, provided such drug is a covered drug under such policy or contract.

(c) Nothing in this section shall (1) preclude an insured or an insured's treating health care provider from requesting a review under sections 38a-591c to 38a-591g, inclusive, or (2) affect the provisions of section 38a-518i.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2018*	38a-510
Sec. 2	*January 1, 2018*	38a-544

Statement of Purpose:

To limit coinsurance, copayments, deductibles and other out-of-pocket expenses imposed on insureds for prescription drugs.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]

Co-Sponsors: SEN. LOONEY, 11th Dist.

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